

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10640 **CERTIFICATE OF DEATH**

10646

Reg. Dist. No. 64

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Caroline</u>		STATE <u>Maryland</u> COUNTY <u>Caroline</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg - Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg - Rural</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg - Rural</u>		LENGTH OF STAY (in this place) <u>Life</u>		TOWN <u>Federalsburg - Rural</u>		TOWN <u>Federalsburg - Rural</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Near Friendship</u>				STREET ADDRESS (If rural give location) <u>Near Friendship</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Russell</u> <u>Edwin</u> <u>Andrew</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>November 15</u> <u>1955</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>October 25, 1900</u>	9. AGE last birthday <u>55</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Owner</u>		11. BIRTHPLACE (State or foreign country) <u>Caroline County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert T. Andrew</u>				14. MOTHER'S MAIDEN NAME <u>Minnie T. Shick</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mrs. Ruth E. Andrew, Federalsburg, Md.</u>			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>433.10</u> IMMEDIATE CAUSE (A) <u>Stokes-Adams Syndrome</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Chronic Myocarditis +</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Heart Block.</u>				18. MEDICAL CERTIFICATION INTERVAL BETWEEN ONSET AND DEATH <u>Spr.s</u> <u>Spr.s.</u>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1950</u> , 19 <u>50</u> , to <u>11/15</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/15</u> , 19 <u>55</u> , and that death occurred at <u>8 A.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Frank M. Anderson</u>				ADDRESS (Street, city, town, state) <u>Federalsburg, Maryland</u> DATE SIGNED <u>11/15/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 18, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Hill Crest Cemetery</u>		LOCATION (City, town, or county) (State) <u>Federalsburg, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>Nov. 16, 1955</u>		REGISTRAR'S SIGNATURE <u>Margaret H. Frampton</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J.J. Frampton and Son, Federalsburg, Md.</u>			

10641

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10647
Reg. Dist.

No. 62

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Talbot</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>rural</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Cordova</u>		<u>20x-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>auto accident</u>				STREET ADDRESS (If rural, give location) <u>rural</u>			
3. NAME OF DECEASED: (First) <u>Hazel</u> (Middle) <u>Grace</u> (Last) <u>Baynard</u>				4. DATE OF DEATH (Month) <u>Nov.</u> (Day) <u>11</u> (Year) <u>55</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>		8. DATE OF BIRTH: <u>Mar. 31, 1917</u>	
9. AGE last birthday: <u>38</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Talbot Co. Md.</u>	
13. FATHER'S NAME: <u>James A. Allen, Sr.</u>				14. MOTHER'S MAIDEN NAME: <u>Blanche Cannon</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Mr. Lester Baynard Easton, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>							

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<p><u>825X</u></p> <p>Immediate cause (a) <u>Shock - Hemorrhage -</u></p> <p>Antecedent cause(s) (b) <u>Multiple Fractures</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)</p>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office hldg., etc., INJURY) <u>Highway</u>		21c. (City or town) (County) (State) <u>Hillabro Caroline Md</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>11- " 55 11:45 M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Automobile accident</u>			
<p>22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/>, Accident <input checked="" type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</p> <p>SIGNATURE <u>Lawson O. George</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>11/15/55</u></p> <p>M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/></p>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>burial</u>		DATE THEREOF <u>11-15-55</u>		NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Easton, Talbot Co. Md.</u>	
DATE REC'D BY LOCAL REG. <u>11/15/55</u>		REGISTRAR'S SIGNATURE <u>Lawson O. George</u>		24. FUNERAL DIRECTOR <u>Maurice E. Newnam & Son</u>		ADDRESS <u>Easton, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 21 1955

RECEIVED

10642

10648

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Caroline</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Caroline</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
<i>Greensboro</i>	<i>2 Months</i>	<i>Templeville</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
<i>None</i>		<i>None</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <i>MARY</i>	(Middle) <i>ELLEN</i>	(Last) <i>BICKLING</i>	(Month) <i>11</i> (Day) <i>18</i> (Year) <i>1955</i>
5. SEX: <i>Female</i>		6. COLOR OR RACE: <i>White</i>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (State): <i>Married</i>		8. DATE OF BIRTH: <i>8/7/1920</i>	
9. AGE last birthday: <i>35</i> yrs.		10. IF UNDER 1 YEAR: Months <i>11</i> Days <i>18</i> Hours <i>55</i> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of work life): <i>Housewife</i>		12. 10b. KIND OF BUSINESS OR INDUSTRY: <i>None</i>	
13. FATHER'S NAME: <i>HICKS BREEDING</i>		14. MOTHER'S MAIDEN NAME: <i>SUSIE WALLS</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <i>No</i>		16. SOCIAL SECURITY No.: <i>None</i>	
17. INFORMANT & ADDRESS: <i>Susie Breeding Templeville, Md.</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <i>accidental drowning</i>			<i>few minutes</i>
DUE TO			
Antecedent cause(s) (b) <i>automobile accident</i>			
Diseases or conditions, if any, giving rise to the above cause (c)			
stating underlying cause last			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH:	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <i>Highway</i>)	21c. (City or town) <i>Rural Greensboro</i> (County) <i>Caroline</i> (State) <i>Md.</i>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>11 18 55-9:20 P.M.</i>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>Automobile accident</i>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>Dawson O. George</i>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <i>11/19/55</i>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>	DATE THEREOF <i>11/21/55</i>	NAME OF CEMETERY OR CREMATORY <i>Mt. Olive</i>	LOCATION (City, town, or county) (State) <i>Near Goldsboro, Md.</i>
DATE REC'D BY LOCAL REG. <i>11/21/55</i>	REGISTRAR'S SIGNATURE <i>L. M. Piggins</i>	24. FUNERAL DIRECTOR <i>J. E. Boulais</i> ADDRESS <i>Greensboro, Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 23 1915

RECEIVED

10643

CERTIFICATE OF DEATH

Reg. Dist. No.

60

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Caroline</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Caroline</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Rural Goldsboro</u>	LENGTH OF STAY (in this place) <u>68 Yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Rural Goldsboro</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>		STREET ADDRESS (If rural give location) <u>None</u>	

3. NAME OF DECEASED:			4. DATE (Month) (Day) (Year)		
(First) <u>Albert</u>	(Middle) <u>K.</u>	(Last) <u>Brown</u>	OF DEATH: <u>11</u>	<u>16</u>	<u>55</u> 19
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>11/15/1887</u>		
9. AGE last birthday <u>68</u> yrs.			10. IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		
11. BIRTHPLACE (State or foreign country): <u>Penna.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		

13. FATHER'S NAME: <u>Harry Brown</u>		14. MOTHER'S MAIDEN NAME: <u>Catherine Long</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>218-20-3653</u>	
17. INFORMANT & ADDRESS: <u>Mable Brown Goldsboro, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<p>2034</p> <p>IMMEDIATE CAUSE (A) <u>Multiple Myeloma</u></p> <p>ANTECEDENT CAUSE (S) DUE TO</p> <p>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.</p> <p>(B) DUE TO</p> <p>(C)</p>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION: <u>1-23-55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Stemal marrow, aspirated: myeloma cells</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Aug. 1, 1955 to Nov. 16, 1955, that I last saw the deceased alive on Nov. 15, 1955, and that death occurred at 10:00 P.M. from the causes and on the date stated above.

23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/19/55</u>	NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>	LOCATION (City, town, or county) (State) <u>Greensboro, Md. Maryland</u>
DATE REC'D BY LOCAL REGISTRAR <u>11/19/55</u>		REGISTRAR'S SIGNATURE <u>G. Clark Smith</u>		24. FUNERAL DIRECTOR ADDRESS <u>J.E. Boulaie Greensboro, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

63

RECEIVED

NOV 23 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 AISC 1-55 104

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10644 **CERTIFICATE OF DEATH**

10650

Reg. Dist. No. 64

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg - Rural</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Federalsburg - Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>River Road</u>				STREET ADDRESS (If rural give location) <u>River Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Mary</u>		(Middle) <u>Elizabeth</u>		(Last) <u>Dickerson</u>		(Month) <u>November</u> (Day) <u>7</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>November 20, 1904</u>		9. AGE last birthday <u>50</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Caroline Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Prattis</u>				14. MOTHER'S MAIDEN NAME <u>Ella V. Dickerson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-12-0220</u>		17. INFORMANT & ADDRESS <u>David Willis, Federalsburg, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>002X</u> IMMEDIATE CAUSE (A) <u>Hemorrhage from lung</u>						<u>4</u> hour	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Pulmonary Tuberculosis</u>						<u>1</u> year	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u> </u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u> </u> <u> </u> <u> </u> <u> </u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/26</u> , 19 <u>55</u> , to <u>11/7</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>11/5</u> , 19 <u>55</u> , and that death occurred at <u>3:20 A</u> .M, from the causes and on the date stated above.							
SIGNATURE <u>W.C. Harrison</u>				ADDRESS (Street, city, town, state) <u>Hurlock, Md.</u>		DATE SIGNED <u>11/8/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Nov. 10, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Federal Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Federalsburg, Maryland</u>	
24. REC'D BY REGISTRAR DATE <u>Nov. 9, 1955</u>		REGISTRAR'S SIGNATURE <u>Margaret H. Frampton</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. J. Frampton and Son</u>		ADDRESS <u>Federalsburg, Md.</u>	

MARYLAND STATE DEPARTMENT OF HEALTH
10645 CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

10651

Reg. Dist. No. 60

1. PLACE OF DEATH- COUNTY <u>Caroline</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Goldsboro</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Goldsboro</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>		STREET ADDRESS <u>None</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Isaac</u>	(Middle) <u>Elwood</u>	(Last) <u>Downes</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>7/16/1893</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	9. AGE last birthday <u>62</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Isaac Downes</u>		14. MOTHER'S MAIDEN NAME <u>Sussie ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>220-01-8374</u>	
17. INFORMANT AND ADDRESS <u>Edith Downes Goldsboro, Md.</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>151X Immediate cause (a) Carcinoma of Stomach</u> <u>Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs -</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
(CITY OR TOWN)		(COUNTY)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .			
SIGNATURE <u>Hanson J. George</u>		DATE SIGNED <u>4/8/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>11/11/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Union</u>		LOCATION (City, town, or county) <u>Goldsboro, Md.</u>	
DATE REC'D BY LOCAL REG. <u>11/9/55</u>		REGISTRAR'S SIGNATURE <u>A. Clark Smith</u>	
24. FUNERAL DIRECTOR <u>J. E. Boulais</u>		ADDRESS <u>Greensboro, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 15 1955

RECEIVED

10646

CERTIFICATE OF DEATH

Reg. Dist. No. 60

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X TOWN <u>Goldsboro</u>		<u>49 Yrs.</u>		TOWN <u>Goldsboro</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<u>None</u>		STREET ADDRESS (If rural give location)		<u>None</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: <u>Elwood</u> <u>Hutson</u>				OF DEATH: <u>11</u> <u>24</u> <u>59</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>8/23/1906</u>	<u>49</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Truck Driver</u>		<u>None</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Thomas Hutson</u>				<u>Richie Longfellow</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>No</u>		<u>222-18-2896</u>		<u>Ida Hutson Goldsboro, Md.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>162X</u> <u>Broncho Pneumonia</u>							
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>Bronchospasms</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 5, 1954</u> , to <u>Nov. 24, 1955</u> , that I last saw the deceased alive on <u>Nov. 24, 1955</u> , and that death occurred at <u>5A</u> , M, from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Charles H. Huescher</u>		<u>Greenboro Md</u>		<u>11-25-55</u>			
M. D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>11/26/55</u>		<u>Mt. Olive</u>		<u>Near Goldsboro, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
<u>11/26/55</u>		<u>A. Clark Smith</u>		<u>J.E. Boulaie</u>		<u>Greenboro, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

DEC 2 1955

BUREAU V. S.

Account of the Bureau of the U.S. Army

10647

10653

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

Reg. Dist.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Caroline</i>	MARYLAND	STATE <i>Delaware</i>	COUNTY <i>Kent</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	OR TOWN
X TOWN <i>Greensboro</i>	<i>2 hrs.</i>	TOWN <i>Rural Felton</i>	<i>46 X - 3</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
<i>None</i>		<i>None</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <i>NOBLE</i>	(Middle) <i>MELVIN</i>	(Month) <i>11</i>	(Day) <i>18</i>
(Type or Print)		(Year) <i>19 55</i>	
5. SEX:	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
<i>Male</i>	<i>White</i>	<i>Single</i>	<i>5/18/1918</i>
9. AGE last birthday:	10. USUAL OCCUPATION (Give kind of work done during most of work life, or, if retired, state occupation)		11. BIRTHPLACE (State or foreign country):
<i>37</i> yrs.	<i>Factory laborer</i>		<i>Delaware</i>
12. CITIZEN OF WHAT COUNTRY?	13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:
<i>U.S.A.</i>	<i>Menson Melvin</i>		<i>Mary Meredith</i>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or, unk.)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:	
<i>No</i>	<i>Unknown</i>	<i>Mary Meredith Felton, Del.</i>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <i>Accidental Drowning</i>			<i>Instant</i>
DUE TO			
Antecedent cause(s) (b) <i>automobile accident</i>			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
		<i>05</i>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>11 18 55 9:20 P.M.</i>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <i>Automobile accident</i>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <i>Lawson George</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>11/19/55</i>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>	DATE THEREOF <i>11/23/55</i>	NAME OF CEMETERY OR CREMATORY <i>Mt. Olive</i>	LOCATION (City, town, or county) (State) <i>Near Goldsboro, Md.</i>
DATE REC'D BY LOCAL REG. <i>11/21/55</i>	REGISTRAR'S SIGNATURE <i>L. M. Pippin</i>	24. FUNERAL DIRECTOR <i>J. E. Boules</i>	ADDRESS <i>Greensboro, Md.</i>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

NOV 25 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10648 CERTIFICATE OF DEATH

Reg. Dist. No. 10654

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Caroline</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Caroline</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Greensboro</u>	LENGTH OF STAY (in this place) <u>70 Yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Greensboro</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Railroad Ave.</u>		STREET ADDRESS (If rural give location) <u>Railroad Ave.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Myrtie E. Pepper</u>		DATE OF DEATH: <u>11</u> <u>13</u> <u>55</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>12/17/1884</u>
9. AGE last birthday <u>70</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>House Keeper</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John P. Pepper</u>		14. MOTHER'S MAIDEN NAME: <u>Emma Parein</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-20-2295</u>	
17. INFORMANT & ADDRESS: <u>Md. Mary Katherine Porter Greensboro.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) DUE TO <u>Carcinoma of Cervix Uteri</u>			
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Apr. 30, 1955</u> , to <u>Nov. 13, 1955</u> , that I last saw the deceased alive on <u>Nov. 13, 1955</u> and that death occurred at <u>10:40 M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Charles H. [Signature]</u>		M. D. <u>11-15-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/16/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Greensboro</u>		LOCATION (City, town, or county) (State) <u>Greensboro, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Nov. 16/1955</u>		REGISTRAR'S SIGNATURE <u>L. MacPippin</u>	
24. FUNERAL DIRECTOR <u>J. E. Boulaie</u>		ADDRESS <u>Greensboro, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOV 25 1955

RECEIVED

J. E. Brennan, Director, FBI

BUREAU V. 3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

10649				10655			
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18							
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 60							
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Rural Marydel</u>		<u>2 Yrs.</u>		TOWN <u>Rural Marydel</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>				STREET ADDRESS (If rural, give location) <u>None</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Alice</u> <u>Blanche</u> <u>Phillips</u>				<u>11</u> <u>12</u> <u>55</u> ¹⁹			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH: <u>10/21/1932</u>	
				<u>Married</u>		<u>23</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Waitress</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Resturant</u>		9. AGE last birthday: <u>23</u>		11. BIRTHPLACE (State or foreign country): <u>Watauga County, N.C.</u>	
13. FATHER'S NAME: <u>Lindsey Huffman</u>		14. MOTHER'S MAIDEN NAME: <u>Maggie Main</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Millard Huffman Lenoir, N.C.</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) <u>Suppuration</u>						<u>Two weeks</u>	
DUE TO							
Antecedent cause(s) (b) <u>1st + 2nd degree burn of body</u>							
DUE TO							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Trapped in burning building</u>							
19a. DATE OF OPERATION: <u>11/13/55</u>				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc., OF INJURY)		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>11</u> <u>12-55</u> <u>3A</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Trapped in burning Room</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Lawson D. George</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>11/12/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Removal</u>		DATE THEREOF <u>11/13/55</u>		NAME OF CEMETERY OR CREMATORY <u>Thomas Cemetery</u>		LOCATION (City, town, or county) (State) <u>Trade, Tennessee Rt. 1</u>	
DATE RECD BY LOCAL REG. <u>11/13/55</u>		REGISTRAR'S SIGNATURE <u>Ch. C. Smith</u>		24. FUNERAL DIRECTOR <u>J. E. Boulais & Sons, Ltd.</u>			
				ADDRESS			

BUREAU V. S.

NOV 21 1955

RECEIVED

11/21/55

10650

10656
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 66

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN <u>Ridgely Rural</u>		<u>17 Yrs.</u>		TOWN <u>Ridgely</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>				STREET ADDRESS (If rural, give location) <u>None</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Gene Edward Rampmeyer</u>				<u>11 23 55 19</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>(Specify)</u>		8. DATE OF BIRTH: <u>1/12/1938</u>	
9. AGE last birthday: <u>17</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Laboratory</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Gustave Rampmeyer</u>				14. MOTHER'S MAIDEN NAME: <u>Marie E. Hickman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Marie Rampmeyer Ridgely, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>919.1</u> Immediate cause (a) <u>Phant. Hemorrhage</u> DUE TO Antecedent cause(s) (b) <u>Inj. that wound to abdomen</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)				<u>Immediate</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>11 23 55 5P</u>				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <u>farm</u>		21c. (City or town) (County) <u>Rural Ridgely Twp</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>11 23 55 5P</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Lamson George</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>11/26/55</u>		NAME OF CEMETERY OR CREMATORY: <u>Ridgely</u>		LOCATION (City, town, or county) (State): <u>Ridgely, Md.</u>	
DATE REC'D BY LOCAL REG. <u>11-26-55</u>		REGISTRAR'S SIGNATURE: <u>Mary E. Davis</u>		FUNERAL DIRECTOR: <u>J. E. Boulaia</u>		ADDRESS: <u>Greensboro, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

130-2

BUREAU V. S.

NOV 30 1955

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J. E. Sullivan

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11761

10651 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Caroline</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Denton</u>		<u>life</u>		TOWN <u>Denton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
60							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) (Middle) (Last) <u>CLARENCE HARTLEY ROE</u>				<u>Nov 30 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>W</u>	<u>Married</u>	<u>Aug 14 1884</u>	<u>71</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY	
<u>Auto dealer</u>		<u>owner</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Thomas F. Roe</u>				<u>Mary Ellen Duke</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>No</u>						<u>Euro Clarence Roe, Denton, Md</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4438 IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage - left, pt. Hemiplegia</u>				INTERVAL BETWEEN ONSET AND DEATH <u>72-96 hrs</u> <u>years</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertensive Cardiovascular Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 15 1955</u> to <u>Nov 30 1955</u>, that I last saw the deceased alive on <u>Nov 30 1955</u>, and that death occurred at <u>1:30 PM</u>, from the causes and on the date stated above.							
SIGNATURE <u>Charles H. Hinnick</u> M.D.				DATE SIGNED <u>12.5.55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				ADDRESS (Street, city, town, state)			
<u>Burial</u>				<u>Denton, Md</u>			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>12/2/55</u>		<u>Wm D O George</u>		<u>J. V. Moore, Son</u>		<u>Denton, Md</u>	

DEC 9 1955

RECEIVED

10652 CERTIFICATE OF DEATH

Reg. Dist. No. 66

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Ridgely</u>		70 Yrs.		OR TOWN <u>Ridgely</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
None				None			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(First) <u>Martha</u>		(Middle) <u>Ann</u>		(Last) <u>Royer</u>		OF DEATH: <u>11</u> <u>24</u> <u>55</u> <u>19</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>8/25/1885</u>	
9. AGE last birthday <u>70</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>Charles E. Bruce</u>				14. MOTHER'S MAIDEN NAME: <u>Emma Ramble</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS: <u>Wayne Royer Ridgely, Md.</u>	
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
260X IMMEDIATE CAUSE							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION: <u>Coronary left heart failure</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID (City or town) (County) (State)				21D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY			
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-22-55</u> , to <u>11-24-55</u> , that I last saw the deceased alive on <u>11-22-55</u> , and that death occurred at <u>8:45 AM</u> from the causes and on the date stated above.							
SIGNATURE <u>Charles E. Winters</u>				ADDRESS <u>Ridgely, Md.</u>			
DATE SIGNED <u>11-25-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>11/28/55</u>			
NAME OF CEMETERY OR CREMATORY <u>Ridgely</u>				LOCATION (City, town, or county) (State) <u>Ridgely, Md.</u>			
DATE REC'D BY LOCAL REGISTRAR <u>11-26-55</u>				REGISTRAR'S SIGNATURE <u>Mary C. Laird</u>			
24. FUNERAL DIRECTOR <u>J.E. Boulain</u>				ADDRESS <u>Greensboro, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

NOV 30 1955

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U. S. DEPARTMENT OF JUSTICE

10653 CERTIFICATE OF DEATH

Reg. Dist. No. 41

10658

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Caroline</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Caroline</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN <u>Greensboro</u>		<u>10 min.</u>		TOWN <u>Rural Goldsboro</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>				STREET ADDRESS (If rural give location) <u>None</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Herbert N. Seth Jr.</u>				DEATH: <u>11</u> <u>25</u> <u>55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED.	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>Col.</u>	<u>Single</u>	<u>9/12/1954</u>	<u>1</u> yrs.	<u>2</u> Months	<u>2</u> Days	<u>19</u> Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Herbert N. Seth Sr.</u>				14. MOTHER'S MAIDEN NAME: <u>Mary H. Henry</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT & ADDRESS: <u>Herbert Seth Goldsboro, Md.</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				<u>15 min</u>			
IMMEDIATE CAUSE (A) <u>Foreign Body in Larynx</u>							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>Home</u>		21C. WHERE DID (City or town) INJURY OCCUR? <u>Greensboro</u>		(County) <u>Caroline</u> (State) <u>Md.</u>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Nov. 25 '55</u> <u>4 P.M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR? <u>Aspiration of screw into larynx</u>			
22. I hereby certify that I attended the deceased from <u>Nov. 25, 1955</u> to <u>Nov. 25, 1955</u> , that I last saw the deceased alive on <u>Nov. 25, 1955</u> , and that death occurred at <u>5 P.M.</u> , from the causes and on the date stated above.							
SIGNED <u>Charles H. Hines</u>		ADDRESS <u>M. D. Greensboro Md.</u>		DATE SIGNED <u>11-26-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/27/55</u>		NAME OF CEMETERY OR CREMATORY <u>Union</u>		LOCATION (City, town, or county) (State) <u>Goldsboro, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>11/27/1955</u>		REGISTRAR'S SIGNATURE <u>L. Mac Phipps</u>		24. FUNERAL DIRECTOR <u>J. E. Boulaie</u>		ADDRESS <u>Greensboro, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians:—please write the causes of death clearly and legibly.

BUREAU V. S.

DEC 6 1955

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